Appendix 12
Bureau of Health Care Financing
Nursing Home Rate Administrative Review Request

Nursing Home Name: _____

Provider Number: _____

Date: _____

TO: Bureau of Health Care Financing
Nursing Home Section
Administrative Review Committee
Post Office Box 309
Madison, WI 53701-0309

FROM:
Wisconsin Association of Nursing Homes _____
Wisconsin Association of Homes and Services for the Aging _____
Wisconsin Association of County Homes _____
Nonrepresented Nursing Home _____

SUBJECT OR PROBLEM TITLE: _____

Problem Attributes (see instructions - if insufficient space, attach additional sheets)

1. Statement of Condition:

2. Criteria:

3. Cause:

4. Effect:

5. Recommended Solution: